

TODAY'S PROBLEMS IN VOLUNTARY FINANCING MECHANISMS*

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I SHOULD like to begin by making two general statements. First, the problems of financing care are inseparable from the problems of providing care and the problems of buying care. Financing is the bridge between the provision and the purchase of care.

The second general statement is that, in the United States currently, the high-priority problems in financing hospital and medical care are no longer primarily a matter of the amount of money we can afford to spend. Rather, the problems involve public policy and the dialogue that should surround the formation of policy. Our gross national product is large, healthy, growing, and within reason it can provide a great deal of health service. The nation can pay its medical bill without going bankrupt. There is, however, lack of consensus on how the money should be spent, and on the inevitably sticky question of precisely how much *should* be spent, regardless of how much *could* be spent.

What are some of the major issues that deserve scrutiny? I should like to name a few, recognizing that they are links of a chain and not really separable.

CONTROLS

To begin, what is the proper structure for controls in the health system? At the moment we have controls at three levels; at the primary level, we have professional controls exercised by doctors, hospitals, accreditation agencies, and planning councils; through these we have tissue review, review of utilization, standardization, and a methodical appraisal of bed need and bed plans. At the second level are fiscal controls; claims, administration, recertification procedures, audits of need, reimbursement formulas, deductible and copayment provisions, waiting periods, and the like, administered by carriers. At the third level are legal controls; licensure of doctors, licensure of hospitals, definition of the rights of trustees, and building codes.

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Up to now there has been heavy emphasis on professional controls. Now there is a growing interest in fiscal controls and legal controls. Predictably, doctors in hospitals put emphasis on the first level of controls, but the consumer is increasingly calling for greater action at the second and the third levels. A major problem of financing is to know approximately what blend of these three levels of control is desirable in the patient's interest. Candid discussion is rare perhaps because the word control is so harsh and because it essentially suggests a confrontation.

If the health services were rendered in a free market, the proper admixture of these three elements might seem self-evident and would come about almost spontaneously. But medicine is not practiced in a free market. The concepts of a free market are seriously compromised by a lack of true competition, knowledgeable purchase, and freedom to purchase or not to purchase. Furthermore, there is lacking an accepted criterion such as the free market concept of profit in the health field, and the corollary idea of self-interest as an animating force is not accepted. Nevertheless, doctors often act upon the assumption that they are part of a wholly free market. They fail to understand that they are part of a social market and they ignore the fact that when animating forces such as competition are absent, conscious planning for the future must be substituted.

Who is to do this conscious planning, and what sort of plans for fiscal control will be effective? One answer has been to resort to limited payment, deductible copayment provisions and similar insurance devices. These out-of-pocket devices, when effective economically, are often too burdensome to be desirable medically. Further, when such a device might be preferred by the physician, it is often opposed by the hospital; when it might be supported by management, it is often opposed by labor. It is becoming increasingly evident that, for several reasons, expenses should be paid comprehensively and controls should be worked out between the carrier and the provider of care rather than allowing the burden to fall on the relatively ill-equipped individual.

What controls? In regard to capital structure I should suggest that a state-wide mechanism must be found that brings into play the concept of need as opposed to a profligate expenditure of increasingly liberal capital resources. It either has to be franchisement or a combination of that and voluntary effort.

In regard to utilization, I should say that there must be provision in the contract between the purchasers of care and the providers for a routine review of cases from an economic as well as a clinical point of view, and that there must be developed criteria or reference points that are understandable to the buyer as well as to the seller. There is a concept among many who practice medicine that practice is essentially not comprehensible in lay terms and that any attempt to review cases on a rational economic basis will invite excessive control by those who do not understand medical problems. There is also the problem of how to bring in what happens before and after the hospital event as well as scrutiny of the hospital itself.

PRODUCTIVITY

Another major issue in addition to controls over financing is productivity. All of us are well aware that admission rates vary widely according to the extent of coverage one has and the organization of medical practice under which care is received. We know that the ratio of people working in a hospital to patients varies considerably in different sections of the country and also varies within hospitals in the same section even after controls of hospital size. We all are aware of studies that point out the need for some attention to the factors of appropriateness of admission, relevancy of services, and appropriateness of stay.

There is a long list of prescriptions for the ills of productivity. To some, the answer is group practice. Others have suggested greater use of paramedical services as a substitute for the extensive skills of the physician whenever possible. Comprehensive coverage could take some of the pressure off the most acute and most expensive facilities. Or better use of the hospitals, seven days a week. Or better internal management. Or fewer and larger hospitals, all operating above the threshold of efficiency. Or better design of hospitals. The problem is not a lack of worthy opinion in this area; it is how to implement solutions on a community-wide scale. How are we to introduce an appropriate measure of planning to a medical community that resists the idea and to a public somewhat entranced by the mysteries of medicine and not yet in the most rational buying mood—although getting there quickly.

All of us have to take blame for our failure to solve problems when we know the solutions. The hospitals have shown too much tim-

idity in exercising legitimate leadership in areas of medical practice on both an institutional and area-wide basis. Blue Cross and government both have to take blame for not utilizing their purchasing power more constructively. And supporters of comprehensive group practice, I think, must accept some blame for not being willing to settle for half a loaf at times. Instead of promoting group practice along with the wider type of prepayment, too often they insisted on the whole loaf including comprehensive prepayment and forfeited growth and the ability to serve large areas.

The problems of productivity can be solved, but the solutions must involve all of us, and the initial spark must come from the consumer expressing himself through his government and through boards established to give him strong representation. Education and similar mild approaches are important but very slow measures. Productivity of prepayment itself can be improved through a merger of hospital and medical and surgical programs now administered separately, mergers to create plans of optimal size, and increased experimentation and evaluation of new forms of care.

ACCESS TO CARE

A third problem in financing is that of access to care. Without getting into a semantic discussion of whether care is a right, a privilege, a necessity, or what, we must accept the concept that people must have reasonably equal access to it. I say "reasonably equal," because it is impossible to make access absolutely equal in any service having an economic component.

The distribution of physicians varies widely in different sections of the country; prepayment coverage varies with economic groups and with age; physicians' visits vary with race and income. We may assume that some groups are receiving too much care; or that other groups are receiving too little; or that need for medical attention varies in some magical way according to these disparities. All of these assumptions are invalid, of course. The situation is in need of redressing.

There is no question that the total community must have access to care and that care must not simply touch each individual; it must really affect each individual. A problem of the system is how to write coverage, some of which will be new by definition and, further, how to set the provider performance standards to balance effectively the counter-

vailing forces of availability of services and quality of service, e.g., in the nursing home field.

GOVERNMENT-VOLUNTARY RELATIONSHIPS*

Another issue that must be faced in the voluntary financing field is that of government-voluntary relationships. Both private and governmental interests are involved in financing health services and have been for years. In the past, the government has focused on providing medical care for specialty groups, on construction of facilities, and more recently, on research, on community-wide programs, and on welfare assistance. The voluntary section has focused on personal health services obtained through a private physician. The division of responsibility has been relatively well-understood—not always completely accepted, but at least relatively well-understood. Recent programs have begun to raise serious questions about this division. For example, we see the government concerned with nonservice-connected disability coverage for veterans. We see debate over how to care for retired military personnel and now we have, of course, H.R. 6675, which has since been passed by the Congress, signed by the President, and has become Public Law No. 89-97—the Social Security Amendments of 1965 that include Medicare.

Let me start with the assumption that private and governmental services are both natural outgrowths of the community. Private and governmental sectors are not antagonists with vastly different objectives. Nevertheless, some questions need to be answered. For example, when the government assists a person to purchase care, should a carrier be used, or should the government purchase the care directly from a provider? If a carrier is used, which of the many normal carrier services should be utilized? Should individuals be assisted on the basis of need, or by some group classification, or both ways? Should the government set detailed standards and benefits when it formulates legislation or leave the formulation of standards to negotiations between its officers and others? What is the role of the state vis-à-vis the federal government? Is the state still the basic government unit for health service, reflecting vast differences throughout the country, or is there a need for more uniform practices? What agency is there at the state

*See also: McNerney, W. J. *The Future of Voluntary Prepayment*. Wilinsky Lecture, Harvard University School of Public Health, 1965. Unpublished.

level to coordinate other state agencies that may, variously, evaluate the physical effectiveness of an institution, review a substantive program going on within the institution, declare eligibility, and take similar responsibilities? Should the government encourage competing forms of financing mechanisms or should it protect and regulate a few, acting as public utilities?

We need clarification on these questions. In the absence of candor and direct dialogue, there has developed a great deal of anxiety and some maneuvering. We need open discussion, free of cynicism and free of illogical criticism among groups. There is a great challenge before us. I think the new Social Security legislation is going to clarify some of these issues; beyond that I should like to see fuller and more open communication between the government and the voluntary agencies on these numerous issues confronting us.

NEED FOR FIRMER FACT BASE

A fifth problem of voluntary financing is the need for firmer facts concerning the relative advantages of various ways of providing care. What is, on an episodal basis, the effect of group practice, as compared with a loose federation of physicians, and as compared again with physicians individually handling given types of diagnoses? What are general measures of need from which one can, in the absence of a free market and competition as governing devices, project bed and medical manpower needs? I am distressed that the universities have not done more in these and other areas. Perhaps they have not done more because these are hard questions, requiring both money and a tremendous amount of intellectual energy to find the answers. There has been a tendency for universities to become politically involved in the administrative process of change as participants rather than as bodies of scholars providing the generating facts.

There are no simple solutions because we are dealing with the process of psychological and sociological change as well as economics and clinical considerations. We are dealing with the inevitably complex relationship between a buyer and a seller, which is based to some extent on antagonism. We see the very subtle process of the welfare state and free enterprise coming together.

The excessive pressures that have been brought to bear on the financing of medical care could, more profitably, be spread else-

where. Financing is only one element in the form of a bridge. More attention should be devoted to the two areas linked by the bridge—the provision and the purchase of care. It would be highly desirable if those who have been so concerned with criticizing financial proposals would bring their intellectual powers to bear also on increasing medical productivity and assisting the population to purchase care with more intelligence.

In leading to the next topics which deal with what to do about our problems, a few summary points can be made: the consumer must be placed in a more powerful position; it is he who will spark the changes that we need. A good starting point would be early attention to increased consumer control of physical facilities and programs on an area-wide basis. This could be done without a cry going up about manipulation of the individual patient. Next, sets of criteria should be developed for a few high-frequency conditions so that medicine, the hospitals, and the buyers can agree on standards of adequate productivity. Finally, the voluntary financing institutions should be kept under pressure by anyone representing the public who feels he has a case to make. This is a public system. It should feel no special sanction; it has no place to hide. I am confident that it can accommodate provocative pressures and, through innovation, provide even greater service to the people of the United States.